

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL****FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

0 4 — 0 3

2. STATE:

West Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

October 1, 2004

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447. Subpart C;
42 CFR 440.40

7. FEDERAL BUDGET IMPACT:

a. FFY 2005 \$ -0-

b. FFY 2006 \$ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D-1 Pgs. 1, 2, 5, 12, 13,
14, 17, and 189. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

10. SUBJECT OF AMENDMENT:

This plan amendment clarifies the efficiency incentive and deletes the
bed reduction policy and language updates

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ OTHER, AS SPECIFIED:☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

Nancy V. Atkins

13. TYPED NAME:

Nancy V. Atkins, MSN, RNC, NP

14. TITLE:

Commissioner

15. DATE SUBMITTED:

16. RETURN TO:

Nancy V. Atkins, MSN, RNC, NP
Commissioner
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301-3706**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

SEP 20 2004

18. DATE APPROVED:

November 10, 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

OCT - 1 2004

20. SIGNATURE OF REGIONAL OFFICIAL:

Dennis G. Smith

21. TYPED NAME:

DENNIS G. Smith

22. TITLE:

Director, CM SO

23. REMARKS:

4.19 Payments for Medical and Remedial Care and Services

Methods and Standards for Determining Payment Rates for non-State-Owned Nursing Facilities - Excludes State-Owned Facilities**I. Cost Finding and Reporting**

All nursing facilities certified to participate in the program are required to maintain cost data and submit cost reports according to the methods and procedures prescribed by the State agency.

A. Chart of Accounts

The Department adopted the Chart of Accounts for Long Term Care Facilities published by the American Nursing Home Association as the basic document for the LTC system July 1, 1975. The basic chart of accounts is updated and modified periodically and has been converted to a mandated computerized format. This standard computerized cost reporting mechanism must be used by all participating facilities to maintain facility cost data for cost reporting and auditing purposes.

B. Financial and Statistical Report

Facility costs for nursing facilities must be reported on the computerized format of the Financial and Statistical Report for Nursing Homes. These reports must be completed in accordance with generally accepted accounting principles using the accrual method of accounting and must be complete and accurate. Facilities are also required to submit a trial balance of the reporting entity as of the closing date of the reporting period. Incomplete reports or reports containing inconsistent data will be returned to the facility for correction.

C. Cost Reporting Periods

All participating facility costs are reported semi-annually. The six-month reporting periods are January 1st through June 30th, and July 1st through December 31st.

D. Filing Periods

Cost reports must be filed with the State agency and postmarked within sixty (60) days following the end of the reporting period. The due dates are March 1st for the December 31st closing date and August 29th for the June 30th closing date.

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An extension of time for filing cost reports may be granted by the State agency for extenuating circumstances where requested and justified by the facility in writing by the close of business on the due date. Requests for an extension of the filing period are to be addressed in writing to the Director, Financial Analysis and Rate Setting, Bureau for Medical Services, 350 Capitol Street, Room 251, Charleston, West Virginia 25301-3706.

E. Penalty - Delinquent Reporting

Failure to submit cost reports within the mandated (sixty [60] days) filing period, where no extension has been granted to the facility or within the time constraints of an extension, will result in a ten percent (10%) reduction in reimbursement to that facility. The penalty will be assessed on payments for services delivered on the day(s) the report is late.

Incomplete cost reports returned to the facility for correction which are not promptly completed and resubmitted within specified time constraints, may be subject to the following penalty provision: Facilities submitting cost reports after the beginning of the rate period; i.e., April 1st or October 1st, will receive rate adjustment effective the month following the month the cost report was received.

F. Correction of Errors

Errors in cost report data identified by the facility may be corrected if resubmitted with thirty (30) days after original rate notification. Only those corrections received by the Department within the thirty (30) day period will be considered for rate revision. The Department will make rate revisions resultant from computational errors in the rate determination process.

TN No. 04-03

Supersedes

TN No. 96-15Approval Date NOV 30 2004Effective Date OCT - 1 2004

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by facility classification as determined from the current cost report.

3. Nursing Services

Allowable costs and reimbursement for nursing services will be determined by the kind and amount of services needed by and being delivered to the residents, the staffing required to deliver the care and the restorative and rehabilitative programs offered by the facility. Such determination will be based on the application of a minimum staffing pattern and adjustments to reflect needs determined by case mix characteristics.

Monthly billing forms for services rendered to nursing home residents will include data directly derived from the computerized MDS for each resident, which will be used to determine composite case mix scores for each resident and for the facility. These case mix scores will measure the relative intensity of service needs of the facility residents and will comprise the basis for determining allowable adjustments to per diem staffing and costs required to deliver the kind and amount of services needed.

4. Cost of Capital

Reimbursement for cost of capital is determined using an appraisal technique to establish a Standard Appraised Value (SAV). The value includes the necessary real property and equipment associated with the actual use of the property as a long term care facility. The Standard Appraised Value (SAV) uses the cost approach to value modified by the Model Nursing Home Standard, where appropriate. This valuation is the basis for capitalization to determine a per patient day cost of capital. This allowance replaces leases, rental agreements, depreciation, mortgage interest, and return on equity in the traditional approach to capital cost allowance.

a. Cost Approach to Value

The value of a property is derived by estimating the replacement or reproduction cost of the improvements, deducting them from the estimated accrued depreciation, and adding the market value of the land (actually used or required for use as if vacant and available for

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Multiplying these PPD staffing patterns by the 70th percentile value of hourly wages, based on total compensation for the peer group yields the nursing services CAP, or ceiling, for each facility in the peer group.

A factor is added for supplies equal to the PPD supply costs at the 70th percentile for the bed groups determined from the submitted cost reports. An additional factor is added for the Director of Nursing (DON) by dividing the DON salary at the 70th percentile from the bed range, as derived from the submitted cost reports, by each facility's beds at 100% occupancy. Adding these factors together yields the base constant through the six-month reimbursement period.

The peer group CAP is then adjusted to a facility specific CAP based on that facility's average MDS score from the six month reporting period. The average MDS is divided by 2.5 and then multiplied by the base constant to arrive at an adjusted nursing CAP for each facility. The adjusted nursing CAP cannot exceed 112% (MDS average of 2.8), or be less than 80% (MDS average of 2.0), of the base constant.

An add-on factor allows for monthly adjustments to this base nursing reimbursement during the reimbursement period when the case mix score derived from the MDS, as determined at the time of monthly billing, indicates a higher level of need and care delivered to a resident in a given facility. A base case mix score of 2.9 is established as a threshold. For residents with a monthly case mix score of 2.9 or less, there is no add-on factor. If the monthly case mix score exceeds 2.9, then an add-on factor is determined by dividing the excess of the case mix score over 2.9 by the threshold factor of 2.25. The resulting factor is then multiplied by the Nursing Rate to derive a PPD nursing services add-on.

5. Minimum Occupancy Standard

Cost adjustments will be made by applying a minimum occupancy standard of 90% of all cost centers. Actual facility occupancy is used to determine allowable cost per patient day if equal to or greater than 90%. When the actual occupancy level is less than 90%, the actual allowable per patient day cost will be adjusted to assume a 90% occupancy level.

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An efficiency incentive will be allowed where the standard services area allowable costs are less than the total of the cost ceilings. Fifty percent (50%) of the difference between the allowable costs and the cost ceiling will be applied to the prospective rate for the standard services area. The total of the calculated efficiency incentive may not exceed \$2.00 per patient day.

Quality Assurance

A facility qualifying for efficiency incentive shall not have any deficiencies related to standard services or substandard care, quality of life, and/or quality of care as defined by the surveying agency during the reporting period. Survey and licensure agency reports are reviewed to determine compliance with licensure, certification and agency standards. If it has been determined that a facility has significant deficiencies, the facility will be denied efficiency incentive for that period.

C. Inflation Factor

After combining the various components, a factor is assigned to costs as a projection of inflation during the next rate-setting cycle. In setting an inflation factor, changes in industry wage rates and supply costs compared with CPI are observed and the lesser amount of change is expressed as a percentage and applied to the allowable reimbursable costs for the six-month rate setting period. The amount of change experienced during the six-month reporting period or the CPI becomes the inflation factor applied to the next six-month rate setting period. The inflation factor, once set for a given rate period, is not adjusted as it represents a reasonable expectation for cost increases.

Indicators used for tracking economic changes and trends include:

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- I. Semi-Annual Cost Reporting - The average per patient day cost of service is compared to the cost incurred in providing the same services in the prior cost reporting period. The percentage of change is then expressed as an increase or decrease in the cost from the prior period.
- II. Regulatory Costs - Regulatory costs, such as minimum wage increase, FICA increase, and Worker's Compensation changes may be considered as a component of the inflation factor.
- III. National Data - The Consumer Price Index (CPI) for the most current cost reporting period is analyzed and compared with state experience.

D. Change in Bed Size

A cost adjustment may be made during a rate period where there has been a change in the facility bed size if it affects the appraisal value of the facility. In this instance, an appraisal of the facility will be completed after the change in bed size has been certified. Any revision of the per diem rate as a result of the change in bed size will become effective with the month the facility changes were certified by the state survey agency.

E. Projected Rates

Projected rates will be established for new facilities with no previous operating experience for a period of eighteen (18) months. The facility may choose to go off the projected rate at any time after a full six (6) months of operating experience in a cost reporting period. Projected rates may be established for a maximum period of eighteen (18) months where there has been a change of ownership and control of the operating entity, and the new owners have no management experience in the facility. Where there has been a change of ownership from a corporation to an individual or individuals, from an individual or individuals to a corporation, or from one corporation to another, the ownership of the stock of the corporation(s) involved will be examined by State agency in order to determine whether there has been an actual change in the control of the facility. Where ownership changes from an individual to a partnership, and one of the partners was the former sole owner, there has been no change of control.

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Financial and statistical reports submitted by the participating facilities will be subjected to desk review and analysis for rate setting within sixty (60) days of receipt. Incomplete and inaccurate cost reports are not accepted.

B. Field Audit

Periodic on-site audits of the financial and statistical record of each participating facility will be conducted to assure the validity of reported costs and statistical data. Facilities must maintain records to support all costs submitted on the Financial and Statistical Report, and all data to support payroll and census reports. These records must be maintained at the facility or be made available at the facility for review by Department staff for audit purposes upon notice. Records found to be incomplete or missing at the time of the scheduled on-site review, must be delivered to the Department within forty-eight (48) hours or an amount of time agreed upon by audit staff at the exit conference. Costs found to be unsubstantiated will be disallowed and considered as an overpayment.

C. Record Retention

Audit reports will be maintained by the agency for five (5) years following date of completion.

D. Credits and Adjustments

The State will account for and return the Federal Portion of all overpayments to CMS in accordance with the applicable Federal laws and regulations.

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VI. Bed Reservation Policy

Reimbursement will be made to reserve a bed during a resident's temporary absence from the facility at the established per diem rate provided the facility is fully (95% or greater) occupied and has a waiting list for admissions. A day of absence is defined as a twenty-four (24) hour period.

Medical Leave of Absence

A bed may be reserved for a resident who is admitted to an acute care hospital for services that can only be provided on an inpatient basis, and whose stay is more than twenty-four (24) hours.

The maximum number of days of medical leave for a resident is twelve (12) days in a calendar year.

Therapeutic Leave of Absence

A bed may be reserved for a therapeutic leave which is included in the resident's plan of care.

The maximum number of days of therapeutic leave for a resident is six (6) days in a calendar year.